



## KBRC NEWSLETTER 2007 Fall / Winter Edition

### OUR MISSION STATEMENT

The Kentucky Board of Respiratory Care is a Government Agency that regulates respiratory care practitioners and their services. The KBRC was established in 1990 to protect the citizens of the Commonwealth of Kentucky from unsafe practitioners and practices.

### Board Information

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Contact Board : (859) 246-2747,

Fax: (859) 246-2750 or online at :

<http://kbrc.ky.gov>

*Above photo courtesy of the AARC photo archive.*

### Important 2008 Renewal News

The KBRC will offer online license renewals starting Nov. 15, 2007 and ending midnight EST. Jan. 30, 2008. The renewal fee is \$75.00 with an online convenience fee of \$3.00 for a total cost of \$78.00. The following payment methods will be accepted: MasterCard, Visa and ACH Debit. Upon completion of the renewal process, you will receive a printable receipt for your record and an updated renewal card will be mailed to you ASAP. Therapists that are audited will get a renewal form mailed to them and therapists who decide to renew by mail must contact the KBRC office or print a renewal form from the KBRC website. Once the online renewal window is closed it can not be reopened. Be aware that the following can keep you from a successful online renewal: Any felony or misdemeanor, credit card denial, insufficient funds, last second renewing before deadline, a defaulted KHEAA loan or a natural disaster. Be a professional and take care of your renewal early. If you have questions about the renewal process or need to change your address or name, please contact the Board office at: (859) 246-2747 for assistance.



### Online Verification of Licensure

The KBRC now has online individual verification of respiratory care therapists. This is for verification only. You may use this online database to find out your license number, original issue date and your expiration date. Follow steps to details page for the information needed. Simply right click and print the verification. There is no fee involved unless you wish to print out an official document.

## Here's some helpful CEU information as we gear up for the 2008 renewal cycle.



**ACLS, PALS - 10 CEUs each, NALS or NRP - 8 CEUs** and all **ACLS & PALS Instructor courses** are 10 CEUs as of 2006 to present. **Educational Classes & College Courses** (All classes approved by the Board are 15 CEUs per credit hour.) **All health and medical college courses must be 300 level or above to be considered CEU worthy.** Note: Only licensed therapists can use college courses for CEU purposes. **Students cannot use college courses for future CEU credit.** Be careful when trying to use nursing

CEUs. Make certain that they have either been approved by the AARC for a determined amount of CEUs or the KBRC has approved them. Some nursing ACLS courses give more CEUs than the KBRC can allow. **Respiratory only gives 10 CEUs for ACLS.** A list of approved/denied CEUs can be located at our website: <http://kbrc.ky.gov>. CEUs are only viable for two years from date of approval.



**It is a violation of KRS 314A.220(3) to practice respiratory care in Kentucky unless the individual holds a valid certificate. Apart from Board discipline, any person who violates this statute may be prosecuted criminally for a misdemeanor under KRS 314A.990(1). The penalty for the misdemeanor conviction may include imprisonment in the county jail not to exceed six (6) months and/or a fine not to exceed \$1000.**

**Consider the case of LE who practiced respiratory care without a valid certificate and provided a copy of an altered certificate that had been previously issued to him to imply that he was currently licensed by the Board. He was indicted and prosecuted by the Jefferson County Commonwealth Attorney's Office for Possession of a Forged Instrument (felony) and Practicing without a License (misdemeanor). LE was sentenced on September 13, 2007, to two (2) years probated for five (5) years with the sentence of imprisonment to be suspended. He was ordered to pay restitution of \$3,038.88 and monthly supervision fees.**

**The lesson here....renew your certificate timely and do not practice without a valid certificate.**



## **Lapsed Licensure—No Licensure**



At the February 2007 meeting the Board discussed guidelines for legal counsel to take actions against individuals who have worked without proper license. The Board charged legal counsel and staff to issue Agreed Orders to those individuals found to have worked illegally. Suspensions of up to two (2 weeks) and fines up to \$750 (\$50 per day) were issued. Any person fined over \$750 and suspended more than two (2) weeks, would need approval by the Board at its next scheduled meeting before a license could be reissued.

## **Oral Surgery Can Reduce CPAP Needs In Patients With Sleep Apnea**

A procedure known as uvulopalatopharyngoplasty (UPPP) may help some patients improve or even eliminate their obstructive sleep apnea (OSA), according to a new study. The research, presented at CHEST 2007, the 73rd annual international scientific assembly of the American College of Chest Physicians (ACCP), says the procedure, which removes excess tissue in the throat or mouth to widen the airway, can reduce the amount of treatment required by patients with OSA. In addition, researchers say UPPP also can eliminate OSA completely in some patients.

"Continuous positive airway pressure, or CPAP, is a well-established treatment for sleep apnea," said lead study author Akram Khan, MD, Assistant Professor, University of Florida Jacksonville, "and while most patients tolerate it well, some are unable to tolerate it or don't want to, and those patients need alternative means of treatment."

To determine if UPPP provided improvement in sleep parameters, Dr. Khan and his colleagues from the Mayo Clinic, Rochester, MN, evaluated the success of the procedure in 63 patients aged 18-80, with OSA, over a 7-year period. All patients underwent UPPP and were assessed with polysomnography within a 6-month period, pre-procedure and post-procedure.

Results showed that UPPP eliminated OSA in approximately one quarter to one-third of patients, depending on the definition of success. Of those who experienced residual OSA and returned to CPAP use, the required CPAP setting was modestly lower. In addition, researchers reported that UPPP also reduced the mean apnea-hypnea index in patients.

"The apnea-hypnea index basically tells us the number of times a patient with sleep apnea quits breathing per hour," Dr. Khan explained. "We found that the surgical procedure reduced patients' apneic (nonbreathing) episodes by more than half." According to Dr. Khan, UPPP provided an improvement in oxygen levels and other parameters of sleep, as well.

First described in 1981, UPPP has been used widely with varying results. Though researchers are unclear on what characteristics make up the ideal UPPP candidate, they suggest that patients with mild OSA, who are relatively young, lean, and healthy, may have the best results with this procedure. Researchers also believe that a decrease in CPAP requirements would likely improve compliance in patients who don't have their OSA completely resolved.

"Obstructive sleep apnea increases the risk of other illnesses, such as heart disease, high blood pressure, and stroke, among others," said Alvin V. Thomas, Jr., MD, FCCP, President of the American College of Chest Physicians. "Patients and physicians need to work together to recognize the signs of sleep apnea and to identify which method of treatment is most suitable."

*Article adapted by Medical News Today from original press release.*

**Source: Deana Busche**

**American College of Chest Physicians**

## **Sorting Out Scope of Practice Issues**

### **It's not an out-and-out turf battle between the sleep and respiratory care professions, not yet.**

Article by Mike Gibbons

The professions of respiratory care and polysomnography are bumping and jostling each other these days like two NBA centers trying to secure position under the basket. Registered polysomnographic technologists want to rewrite state medical licensure laws so they can perform procedures that most states only allow licensed respiratory therapists to do. RTs insist that polysomnographers must first pass the appropriate tests and come under appropriate regulation before performing these procedures. Polysomnography, a young field, wants professional autonomy. Respiratory care, a much older field, wants the licensure protection it fought for years to obtain, state by state. Making it even more interesting is the fact that respiratory care, like an older brother, nurtured the younger field through some of its growing pains. Wized respiratory care leaders helped PSG officials create their own scholastic accreditation system, for example. Now little brother has grown up and broken free. It might all just be a simple matter of changing some language in a few position papers and proposed legislation. Or it could fester into a deeper, more protracted struggle.

At one end of the court is the Association of Polysomnographic Technologists, Westchester, Ill. "Conflicts occur when one health profession's scope of practice has statutory protection in the form of a state practice act," states one muscular APT position paper. "Barriers to competent, effective and accessible care can result. This is now happening between polysomnographic technology and respiratory care." APT leadership declined repeated interview requests from ADVANCE, choosing instead to "work collaboratively" with respiratory care officials, said APT spokesman Chris Waring.

On the other side is the American Association for Respiratory Care, Irving, Texas, which is still waiting to hear from the APT. "I haven't discussed this issue with them, simply because they seem to want to go their own way regardless of what we want to do," said AARC Executive Director Sam Giordano, MBA, RRT. "Well, it's a free country." Then he added: "We're not that far apart." Far enough, though.

#### **APT Position Paper**

In May 2003, around the same time the AARC was issuing its guidance document outlining respiratory care's scope of practice, the APT released a position paper seeking professional autonomy for RPSGTs. "Procedures such as the application and titration of continuous and bilevel positive airway pressure, oxygen therapy and, in some instances, pulse oximetry and capnography performed during sleep studies, all come under statutory definitions of respiratory care and, as such, are limited to individuals licensed under or exempt from provisions of the respiratory care practice act of that state," the APT paper states. Much language in respiratory care practice acts, the APT contends, "was adopted prior to the widespread recognition and acceptance of diagnostic/therapeutic intervention for sleep disorders, especially sleep apnea." RPSGTs "can safely and competently" treat patients with CPAP/bilevel devices by virtue of the knowledge, training, skills and experience they demonstrate by passing their registry exam, the paper continues. Restricting RPSGTs from performing these procedures "can adversely impact the availability, safety and quality of PSG monitoring, diagnostic and therapeutic services to patients in that state."

#### **Exemption Sought**

To rectify the situation, the APT seeks to rewrite licensure laws in the 45 states that have respiratory care practice acts in place. Individuals pursuing the RPSGT credential should be exempt from respiratory care practice acts for up to 36 months, the APT suggests, "provided they practice under appropriate supervision and comply with published job descriptions sanctioned by the APT and the other governing bodies of sleep medicine." (Continued on next page)



The APT already has drafted a model for state exemption language and definitions. It includes under the performance of PSG several tasks now designated under state respiratory care practice acts. They are:

- applying and titrating CPAP/bilevel devices in spontaneously breathing patients
- applying and titrating supplemental oxygen and related equipment
- applying and monitoring pulse oximetry and capnography
- measuring cardiorespiratory volumes, pressure and flow "to assist in diagnosis, monitoring, treatment and research of sleep and waking disorders"
- teaching patients about using and complying with all of the above procedures.

#### Overlap Common

In response, respiratory care's leaders say they have no issue with RPSGTs performing duties that overlap with those of RTs, such as CPAP titration and other sleep-related procedures. "Overlaps exist throughout health care," Giordano pointed out. However, the AARC is troubled by two things. First, as Giordano and others read it, the APT exemption model appears to ask for a blanket exemption not just for these overlapping duties but for all respiratory care duties: managing mechanical ventilators, intubation, chest physiotherapy, asthma care, you name it. "The exemption language is troublesome for us because it is an exemption from the entire scope of practice of respiratory care," Giordano said. "There are no qualifiers as to limits. Theoretically, this would allow those individuals to be exempt from the entire (respiratory care) practice act. A limited exemption would seem to be the way to go. As we say in our guidance document (found at [www.aarc.org](http://www.aarc.org)), they should be allowed to provide the services they are tested on. It's common sense."

#### No Regulation

Secondly, the proposed APT legislation is flawed for not authorizing any state regulators to oversee the exemption system, the AARC charges. "The language we saw did not authorize any state agency to monitor compliance with the conditions," Giordano said. "The APT put some requirements in there regarding experience level, etc., but who's going to monitor those things? It's not regulated at all. Why do you want to regulate (respiratory therapists) but not others?" Even now, he said, "a lot of people are providing polysomnographic services who are not credentialed, who don't have the RPSGT credential, and who are not formally educated. That's just the way new fields start. That's how we started." Inconsistent licensing can create confusion in a sleep lab, agreed Patricia Doorly, MS, RRT, clinical services coordinator for the eight-bed sleep lab at the University of Virginia Medical Center in Charlottesville. "We employ RPSGTs, who then follow the protocols of our pulmonary sleep physicians," Doorly said. "In the state of Virginia, polysomnographic technologists are not required to be licensed by the state, but RTs are. "This can create a confusing environment for practice, especially for those employees who are not registered polysomnographic technologists."

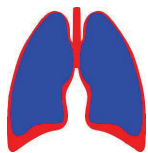
#### Limited Licensure

Some state regulatory boards have offered a "limited licensure" for PSG professionals, that is, allowing them to perform the sleep-related tasks in question — but only in a sleep disorders center and only under the supervision of a licensed physician. The APT balks at this as well. Limited licensure, it contends, would require sleep professionals to apply to respiratory care's regulatory bodies for permission, to pay fees, and to obtain CEUs to renew their licenses. Limited licensure "threatens the autonomy of the PSG profession, and is inconsistent with our goal of establishing PSG as a separate and distinct allied health profession," the APT position paper states. Instead, the APT supports exempting PSG professionals from respiratory care practice acts based on the integrity of sleep medicine's professional credentialing process, practicing under doctor supervision or "on the basis of demonstrated competency for the specific tasks in question." Giordano stressed that the AARC doesn't insist that RPSGTs take and pass the same examinations RTs must take, those administered by the National Board for Respiratory Care.

#### Cordial Note

Respiratory care state societies, meanwhile, are free to adopt their own positions on this scope of practice issue, Giordano said. Officials of the Idaho Society for Respiratory Care have done just that. (Continued on next page)

They recently persuaded lawmakers to upgrade Idaho's respiratory care practice act to require PSG professionals to "obtain a state-issued permit similar to licensure and to be regulated under the Idaho Respiratory Care Board." While he hasn't spoken directly to APT higher-ups, Giordano did participate in a conference call requested by members of the New Jersey Respiratory Care Society that included an APT lobbyist and some APT leaders. "The call went very well," Giordano said. "It was cordial. They understood our concerns. I was left with the impression that they would attempt to address those concerns." Giordano struck a cordial note of his own in closing. "I hope over time people will work through these issues," he said. "We're not very far apart on this. It's a question of how do we allow persons to provide services, assure their competency to do so, and assure the safety of patients. "There's plenty of room for everybody," he said. "There is a huge need. This is not the first time different disciplines do some of the same things, and it won't be the last. "That doesn't mean one is better than the other or worse. It allows the marketplace, the people who hire, to make a selection based on the skills of graduates."

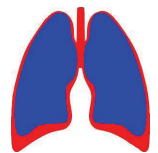


### **Keeping Lungs Young**

Sunday, September 23, 2007

San Francisco Chronicle

Nayer Khazeni, M.D.



You may not see it - as you do your first gray hair or wrinkle, or feel it, as you do your first achy joint. But around age 30, a similar decline will begin in the two most important organs in your body: your lungs.

Your lungs grow proportionally to your height throughout childhood and adolescence, with boys achieving slightly higher maximal volumes than girls. Some variation can occur: youths who perform regular aerobic exercise attain higher volumes, and those taking oral corticosteroids lower volumes. In healthy nonsmokers, lung function peaks between the ages of 20 and 30, followed by a gradual decline throughout adulthood. Smokers experience an earlier peak and an earlier and more accelerated decline.

Measures commonly used to assess lung function include FEV1 (forced expiratory volume at 1 second - volume exhaled in the first second of a forced exhalation from maximal inhalation) and DLCO (diffusing capacity of the lung for carbon monoxide - gas exchange capacity). Normal values depend on sex, height, weight and race. A 5-foot-5-inch white woman could be expected to have an FEV1 of 3.2 L and DLCO of 25 mL/min/mmHg. In nonsmokers, once lung function begins to decline, FEV1 decreases at a rate of 20-30 mL/year and DLCO 0.1-0.4 mL/min/mmHg/year.

What anatomically occurs in your lungs during this decline resembles a very mild form of a disease mainly seen in smokers: emphysema. There is a breakdown in the walls of alveoli, small sacs in your lungs that perform the important tasks of eliminating carbon dioxide and acquiring oxygen. This process of gas exchange occurs where alveolar walls meet capillary (small blood vessel) walls. As alveolar walls break down, there is less functional surface area for gas exchange (reflected by the decrease in DLCO) and lower functional lung volumes (reflected by the decrease in FEV1). Your lungs are also working against stiffening of your chest wall and decreasing strength in your respiratory muscles with aging.

Studies suggest that maintaining good lung function can decrease your risk for dementia, lung cancer and cardiovascular disease. Just as you can limit development of wrinkles, you can limit lung function decline. Don't smoke, and avoid significant exposure to secondhand smoke, gases, dusts, fumes and pollution. If you must live or work in such environments, wear a particulate mask during exposures. If you are a smoker, it's important to quit: Your rate of decline will eventually revert to those of nonsmokers. Obtain daily-recommended doses of Vitamin C from diet or supplements: Its antioxidant properties may be protective. Most importantly, exercise: several studies have found an attenuated rate of lung function, probably by limiting accumulation of inflammatory markers, improving respiratory muscle strength, and decreasing chest wall stiffness.

An interesting preventive method has just been reported (released ahead of press) in a study in the peer-reviewed American Journal of Respiratory and Critical Care Medicine: Statins (medications commonly used to treat high cholesterol) may decrease the rate of lung function decline. The study was observational and limited in its methodology, so keep an eye out for clinical trial data to verify this data. There's hair dye and plastic surgery for some changes of aging. But your lungs' wrinkles and grays are permanent, so take good care of them now. Dr. Nayer Khazeni specializes in internal medicine and pulmonary/critical care, teaches and conducts research at Stanford University Medical Center. This article appeared on page P - 6 of the San Francisco Chronicle.

# Get to know your KBRC Board members

## Congratulations to Tami McDaniel, RRT



Congratulations to Tami McDaniel, RRT. Tami was elected President of the Kentucky Society of Respiratory Care (KSRC) Sept. of 2007. Her dedication and service as a Board member for the Kentucky Board of Respiratory Care (KBRC) will no doubt reflect the quality of commitment she will bring to the KSRC position. Tami McDaniel joined the Kentucky Board in Oct. 2005 and brings with her 20 years of experience as a Respiratory Therapist. Tami is also an American Lung Association volunteer serving as Respiratory Therapist recruiter for Camp Superkids. She has worked at the Ephraim McDowell Regional Medical Center in Danville for over 14 years and currently serves as a Clinical Resource Therapist.

## Important NBRC news about your CRT or RRT Credential

If you passed and received your CRT credential after the date of July 1, 2002, please review this statement regarding NBRC Credentials.

Anyone receiving a credential from the NBRC after July 1, 2002 will be required to show competencies to the NBRC beginning July 1, 2007. [www.nbrc.org](http://www.nbrc.org) How will this affect you with the KBRC?

KRS 314A.110 (5) states: Respiratory therapists applying for mandatory certification, who received their National Board for Respiratory Care certified respiratory therapist (CRT) or registered respiratory therapist (RRT) credential prior to July 1, 2002, shall retain their National Board for Respiratory Care (NBRC) designations as certified respiratory therapists (CRT) or registered respiratory therapists (RRT). Those respiratory therapists applying for mandatory certification who receive their CRT or RRT credential from the NBRC after July 1, 2002, shall retain the CRT or RRT credential as long as they have fulfilled the National Board for Respiratory Care continuing competency program requirements. Persons holding a mandatory certification through the limited mechanism of grandfather status and those respiratory therapists, receiving their CRT or RRT credential after July 1, 2002, who does not fulfill the National Board for Respiratory Care's continuing competency requirements shall solely be designated as respiratory care practitioners.

The KBRC strongly encourages everyone who was awarded a credential after July 1, 2002 to maintain that credential with the NBRC. If you do not maintain your NBRC credential you will not be able to use that credential in the state of Kentucky. You will be required to use the designation respiratory care practitioner (RCP).

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**KBRC Online Renewing Window - Nov. 15th - Jan. 30, 2008 Midnight EST**

**Upcoming KBRC Board meetings -Thursday, December 13, 2007 – Dinner meeting @ 5:30 p.m., Spindletop Hall 3414**

**Ironworks Pike**

*(See the upcoming KBRC Board meeting schedule for 2008 at the About Us page of our website.) <http://kbrc.ky.gov>*



If you did not get a chance to read the last issue of the KBRC Newsletter, You can still find it available at the KBRC website: <http://kbrc.ky.gov>  
The KBRC website can help you find answers regarding your licensure, scope of practice, continuing education and verification questions. The Board's office will also take your questions over the phone at: (859) 246-2747 Fax us at: (859) 246-2750



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